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## Therapeutic Factors in Small Groups : A Review of the Literature Since 1985

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## USE OF THESIS

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- Paper one: Therapeutic factors in small groups: A review of the literature since 1985.
- Paper two: Group member and group leader behavior: Do they make a difference to feelings of cohesion and universality.

A report submitted as a partial requirement for the degree of Bachelor of Arts with Honours in Psychology at Edith Cowan University.

October 1999

I declare that this written assignment is my own work and does not include:

- (i) material from published sources used without proper acknowledgement; or
- (ii) material copied from the work of other students.

Signature:..........

I would like to extend sincere thanks to my supervisor Greg Dear for his invaluable support and guidance in producing this work.

My gratitude to the Holyoake Institute for allowing me to conduct my research in their agency and a special thanks to the clients for their participation in the study.

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This manuscript has been prepared as two separate papers. The structure is an option offered to all Psychology Honours students at Edith Cowan University. Each paper is presented separately and stands independently with its own numbering system, starting at page one. The first paper is a review of the literature and is prepared in accordance with the instructions for the Journal, "Small Group Research". A photocopy of the instructions for submitting publications is located in Appendix A. The second paper is a study and is prepared in accordance with the instruction for the "International Journal of Group Psychotherapy". A photocopy of the instructions for submitting publications is located in Appendix A. To meet the criterion for publication in the selected journals U.S. spelling had been adopted in both papers.

The Manuscript has its own separate appendices located after the second paper.

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Therapeutic factors in small groups: A review of the literature since 1985.

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## Abstract

This article reviews 23 studies post 1985 that measure therapeutic factors. In particular, the current review investigates whether research post 1985 has addressed the specific areas identified by Bloch and Crouch, (1985) and Butler and Fuhrman (1983) as needing further investigation. Areas of study under investigation are (i) behavioral evidence for therapeutic factors, (ii) the relationship between therapeutic factors and treatment outcome, (iii) the relationship between therapeutic factors and individual differences, (iv) the association between therapeutic factors conditions of change and techniques. Studies reviewed were categorized into Inpatient and Outpatient settings. Only one study used observational methods, with the remaining studies using self-report questionnaires. Yalom's 60-item questionnaire, Yalom's Q-sort, (or modifications of these tests), and Bloch et al's, Critical Incident Questionnaire were the most commonly used instruments. The majority of studies focused on therapeutic factors and group differences. There was to a lesser degree research carried out in the area of therapeutic factors and treatment outcome, and the association of therapeutic factors and group development. Several studies used assessment scales to identify individual differences. There was a noted absence of observed behaviors associated with therapeutic factors. Whilst any examination of observed behaviors associated with therapeutic factors was limited.

### Therapeutic factors in small groups: A review of the literature since 1985.

While the notion of therapeutic factors in groups surfaced in the early 1900's, little attention was given to group-based psychological treatments until after the Second World War (Andrews, 1995; Bloch & Crouch, 1985; Forsyth, 1999). Over time, as research has refined the definitions and understanding of group dynamics, the classification, terminology and definitions have changed. Prior to the 1940's the majority of research was mainly focused on technique with little or no reference to group process (Bloch & Crouch 1985). From 1900 to the 1950's therapeutic factors as we know them today were often referred to as group dynamics or expression of dynamics (Corsini & Rosenberg, 1955). Corsini and Rosenberg's review of the literature on psychotherapy highlighted the beginning of the conceptualization of group dynamics and process being partitioned into classes. Their review searched for expressions of dynamics, finding approximately 200 items. These were categorized into nine general classes (acceptance, altruism, universalization, intellectualization, reality testing, transference, interaction, spectator therapy, and ventilation) and a miscellaneous class. The nine factors were further assigned to three broader categories: intellectual, emotional and actional. Corsini and Rosenberg's taxonomy of elements into categories has been a major contribution in creating a benchmark for identifying and refining therapeutic factors related to group process.

In more recent years research has added and refined these classes. Irvin Yalom (1970) produced the most influential work following Corsini and Rosenberg's (1955) study. He based his work on a synthesis of earlier research (Corsini & Rosenberg, 1955), and introduced a 12-factor construct of the curative process in group psychotherapy. He labeled these curative factors and named them as follows; self-understanding, interpersonal learning (input),

interpersonal learning (output), universality, instillation of hope, altruism, recapitulation of the primary family group, catharsis, cohesiveness, identification, guidance, and the "existential" factor. Yalom (1970, p.5) stated that whilst curative factors operate in every type of group, they assume differential importance depending on the goals and composition of the specific group. Furthermore, people in the same group might be benefited by widely differing clusters of curative factors. In addition curative factors are interdependent and neither occur nor function separately. They may also represent different parts of the change process, some refer to actual mechanisms of change, while others may be more accurately described as conditions of change.

During the 1970's a number of researchers (Butler & Fuhrman, 1980; Long & Cope, 1980; Rohrbaugh & Bartels, 1975; Sherry & Hurley, 1976) studied group therapy experience using an instrument based on Yalom's 12-factor model. This instrument is comprised of five statements pertaining to each of Yalom's twelve therapeutic factors. Subjects are required to rate the sixty randomized items on a Likert scale ranging from one to seven, with one representing the construct most helpful and seven being least helpful. For example " Learning that others have some of the same "bad" thoughts and feelings that I do", measures the construct of universality (Yalom, 1970, p.74).

Butler and Fuhrman (1983) presented a more recent review of the literature on therapeutic factors. They identified twelve studies that were categorized into three different types of groups, outpatient psychotherapy groups, personal growth groups, and groups for hospitalized or partially hospitalized psychiatric patients. These studies had used either Yalom's 60-item curative factor questionnaire or a modified version of Yalom's 12-factor construct. Studies identified as belonging to the outpatient category used both instruments. The instruments were consistent in revealing the same therapeutic factors across groups. Therapeutic factors identified

as being valued by the outpatient groups were self-understanding, catharsis, and interpersonal learning (input). The same two instruments were used to measure therapeutic factors in the personal growth groups and like outpatient groups the same consistency across groups was found. For the hospitalized and partially hospitalized patients only two studies were reviewed, with one study on hospitalized patients and the other study on partially hospitalized, therefore no comparisons were able to be made. However, the two studies did reveal different valued therapeutic factors. In the hospitalized group cohesion stood alone in being the most valued therapeutic factor whereas for the partially hospitalized group, instillation of hope was ranked as being the most important therapeutic factor. The limitations of Butler and Fuhriman's (1983) review were the small number of studies in each category.

Butler and Fuhriman (1983), argue that research using Yalom's 12-factor construct was limited because of its reliance on self-report, which only produces information from one perspective, which is the conscious awareness of the group members. For this reason they suggested that further research was required in two areas, the relationship of curative factors to treatment outcomes, and behavioral evidence for the therapeutic factors.

Bloch and Crouch (1985) conducted perhaps the most extensive review of therapeutic factors to date. Their review indicated that there was considerable consistency across the various classifications of basic factors in group therapy that were constructed over more than twenty five years of published work. They also found that there was a general understanding in the literature that the relative importance of a therapeutic factor in a particular group is a function of the group's goals, size, composition, duration, stage of development and other characteristics such as setting and individual differences. Despite the varied foci of the research, Bloch and Crouch found that the terminology relating to therapeutic factors had remained consistent over that

period. They also found across studies, support for ten therapeutic factors which covered three spheres, emotional, cognitive, and actional (behavioral). The terminology used by Bloch and Crouch (1983), closely resembles that of Yalom's (1970) original classification of curative factors (see Table 1).

In terms of comparative effectiveness of therapeutic factors Bloch and Crouch (1985) identified in their review that some form of insight appeared to be linked to improvement. Like Butler and Fuhrman (1983), Bloch and Crouch (1985) also found across studies that the types of groups tended to vary in their perception of therapeutic factors being helpful. In outpatient groups, learning from interpersonal action, insight and self-disclosure were regarded as important. Whereas in comparison, for inpatient groups, it was found that altruism, acceptance and insight were perceived as the most helpful factors. Vicarious learning and guidance emerged repeatedly as unhelpful components in all types of group treatment.

Bloch and Crouch (1985) identified several areas that need further investigation. While some of their suggested areas for further research have been investigated they felt they needed replication. In particular they suggested that further research was required to explore the relationship between highly regarded therapeutic factors and group differences (e.g. long versus short term groups, inpatients versus outpatient groups, homogeneous versus heterogeneous groups). A number of questions also remained to be answered, for example, are therapeutic factors related to individual differences (e.g diagnosis, psychological mindedness, intelligence); what is the association between particular therapeutic factors and outcome; is there a relationship between therapeutic factors and group development; and what is the relationship between therapeutic factors, conditions for change and techniques. These questions pertain to the

importance of identifying those factors that can be encouraged in groups so as to enhance the group therapy effectiveness.

### 1985-1998

The aim of the current review is to identify if in the subsequent years the research has adopted any of Bloch and Crouch's (1985), and Butler and Fuhrman's (1983), recommendations. Studies were identified from a search of Psychlit, Social Work abstracts, and Ovid combining the terms group therapy, curative factors, therapeutic factors with each of the following; universality, cohesiveness, catharsis, instillation of hope, altruism, interpersonal learning, guidance, identification, imitation, family re-enactment, self understanding, existential, self- disclosure, and vicarious learning. The search found 133 English-language journal abstracts. Sixty-six articles were excluded because they were not reporting data (e.g. review of articles, theoretical papers, and commentaries). A further nine were excluded because they were either refining or developing measurements. Out of the remaining 58, 23 were be used for this review because they met the following criteria; English language, original research, published in peer review journals, or edited books.

### Method

The 23 studies were separated into inpatient and outpatient categories (see Tables 2 & 3).

### In-Patients

Table 2 shows that the six inpatient studies covered several setting and populations. These populations included psychiatric patients with various diagnoses, offender groups, and alcohol dependent patients. Furthermore, only one out of the six studied used observational methods to collect data, the remaining five studies used self report questionnaires. There was

also evidence that indicated there was consistency across settings and populations in valued therapeutic factors (Kahn, Webster & Storck, 1986; MacDevitt & Sanislow, 1987). For example, MacDevitt and Sanislow, (1987), used a sample of incarcerated offenders to measure therapeutic factor valued in this population. The sample comprised of 123 subjects, with restrictions ranging from probation, minimal security, maximum security and maximum security under tight security. Whilst they used a modified version of Yalom's 60 -item questionnaire, they did not give any description about how the instrument had been modified. A limitation of the study was its reliance on one self-report measure. The reliance on one measure was limiting because subjects had committed crimes with varying degrees of severity. For example five of the subjects were classified as having behavior management problems and were segregated under tight security. Other offenders were incarcerated for murder and violent criminal assault and sex offences while others had committed lesser offences such as shoplifting. Selection criteria of participants required them to have attended at least three group session. This was strength of the study because the screening procedure requiring prior session attendance gave group members some prior group experience. Across all four groups subjects rated catharsis, and existential awareness as important.

Similar consistency of most valued therapeutic factors across populations was found by Kahn, Webster & Storck (1986), in their study on 124 psychiatric inpatient. Their study compared two groups within the same setting. One group was an awareness group that was designed to facilitate psycho-dynamic change, the second group was a focus group designed to help patients with chronic or severe problems reduce their isolation from others and elicit support. Subjects were assigned to groups according to their diagnosis, level of functioning and goals in treatment. This was strength of this study because the assessment of patient's level of



functioning helped to form more homogeneous groups. Data were collected using a modified version of Yalom's questionnaire, as well as patients rating of their own improvement and the importance of different facets of the treatment program (ward factors). The modifications to Yalom's questionnaire according to the authors were in accordance with Rohrbaugh and Bartels (1975) modifications. The authors gave no description of how the questionnaire was modified. They found that valued therapeutic factors did not differ across group despite the groups having different focuses. In both groups therapeutic factors universality, involvement, instillation of hope and altruism were rated as important.

Adding further support to homogeneity of groups and its effects on valued therapeutic factors is a study by Lovett and Lovett, (1991), on 77 alcohol dependent patients. Subjects were measured at four different stages of treatment using Yalom's 60 item questionnaire. The first measurement was taken at the end of the two-week introductory program; further measurements were taken at week's two, weeks four and at discharge. This was strength of the study because it measured across treatment, which makes findings, related to consistency more valid. They found that the ranking of most valued therapeutic factors remained consistent across time for this population.

An extension of Yalom's 60 item questionnaire is the Critical Incident Questionnaire developed by Bloch, Reibstein, Crouch, Holyroyd, and Themen in 1979, This method involves each participant being given a questionnaire that asks; "Of the events which occurred in today's group, which one do you think was the most important for you personally? Describe the event: What actually took place, the group members involved and your reaction." This system devised by Bloch et al, classifies the critical incidents reports into therapeutic factor categories. Based on the work of Yalom (1975), Bloch et al's category system consists of ten therapeutic factors, self-

disclosure, catharsis, interpersonal learning, universality, acceptance, altruism, guidance, self-understanding, vicarious learning, and instillation of hope. The factors are combined into three higher classes, cognitive factors (self-understanding, vicarious learning, guidance, universality), behavioral factors (self-disclosure, learning from interpersonal actions, altruism), and affective factors (acceptance, instillation of hope, catharsis).

The Critical Incident Questionnaire was the instrument used by Whalan and Mushet (1986), to collect data in their study on 46 psychiatric patients in acute care. Subjects had varying diagnosis such as, schizophrenia, affective disorder, neurotic disorder, personality disorder and alcoholism. There was no information given by the authors as to whether patients with similar diagnosis were assigned to the same groups or not. The Critical Incident Questionnaire extrapolated 163 helpful events from subjects over 22 group sessions. Analysis of the data revealed that the therapeutic factors most valued by subjects were altruism, universality, self-disclosure and guidance. One of the limitations of the study was that it did not differentiate between patient diagnoses. Therefore, it was not possible to determine how differing levels of functioning depending on subject's diagnosis could have effected the findings.

Out of all the studies review in the inpatient setting the most comprehensive study carried out was by Tschuschke and Dies (1994). In their study they used seven instruments to collect their data, (i) the Symptom Check List (SCL-90\_R), that is a 90 checklist used as a general measure of participant reported psychological distress, (ii) the Global Assessment Scale (GAS), which is a forerunner of the current Axis V of DSM-111-R to assess the therapists' rating of the participants overall psychiatric and social functioning, (iii) the Target Goals- Patients, this form requests participants to identify at least three target goals and to rate severity at different points over the course of therapy; (iv) the Goal Attainment Scaling, consists of several steps, the first

step is that seven treatment objectives are formulated by co-leaders, at the post-treatment and follow up assessments an independent clinical evaluator interviews participants and furnishes ratings in relationship to the therapist-defined clinical objectives. On the basis of these four measures a Composite Outcome Scale score was obtained to judge clinical improvement, (v) The Stuttgarter Bogen (Cohesiveness) questionnaire. This semantic differential questionnaire administered to each group session with the instruction, "Today's group I felt..... ". Eight of the 15 items form a sub-scale entitled "Emotional Relatedness to the Group" (e.g., Comfortable-Uncomfortable, Insecure-Self Confident, Protected-Unprotected). This scale is used as a measure for cohesiveness. It evaluates the qualities of support and acceptance described by Bloch et al (1985) as important for cohesiveness, (vi) Kelly's (1955) Repertory Grid was used as an indirect measure of the therapeutic factor of family re-enactment, (vii) the SYMLOG Interaction scoring technique is a method for evaluating group process in terms of three dimensions. Task-Oriented versus Emotional Behavior; Dominance versus Submission; and Positive versus Negative Behavior. Every second group session was scored from videotapes of the group session.

Tschuschke and Dies (1994), studied two long-term analytic inpatient groups of severely disturbed neurotic and personality disordered patients. A major strength in Tschuschke and Dies, study was their use of several instruments in their attempt to measure the association between therapeutic factors and outcome. They found at pre-testing, the most successful patients scored high on the SCL-90-R, as well as on the Target Goal Forms, reflecting more symptomatic distress, than did their less successful cohorts. In addition, they also found that the therapeutic factor cohesion was strongly associated with improvement in both groups ( $r(8) = .94, p < .01$ ;  $r(7) = .74, p < .05$ ). Furthermore, they identified that when cohesion formed early in the group there was a tendency for clinical improvement. Cohesion was measured in the early treatment

groups and again in later groups using the Stuttgarter Bogen Emotional Relatedness to Group Scale. Another strength of Tschuschke and Dies' study was that it was longitudinal with outcome assessments carried out at 12 months and 18 months after treatment. Their study was also the only study found to use observational methods. Further, it was also one of the few studies that measured therapeutic factors and outcome which was one of the suggestions put forward by Bloch and Crouch (1985). However, a limitation of the study was the small sample size of 15.

### Outpatients

Outpatient settings lend themselves to more scope in regards to populations studied. This was reflected in the diversity of populations and as well as a variety of theoretical orientations to group therapy found in the research. There were 17 outpatient studies reviewed in this paper. As with the inpatient settings Yalom's 60 item questionnaire or Q-sort and Bloch and Crouch's, Critical Incident Questionnaire, tended to be the preferred instruments used (see Table 3). There were however, some studies that deviated from these three commonly used instruments (see Table 3). For example Braaten (1990), used three different instruments to measure the association between group climate and cohesion in person centered psychotherapy groups. Prior to therapy he administered the Symptom Checklist 90-R (as described in study by Tschuschke & Dies, 1994) and identified high scores in depression, obsessive-compulsive, interpersonal oversensitivity, and anxiety in his sample. In addition, Braaten (1990), measured cohesion by using two instruments, the McKenzie's Group Climate questionnaire and a cohesion questionnaire developed by the authors. Result obtained from data collected using these two instruments showed that groups session with high levels of cohesion were dominated with the classical dimensions of cohesion in the following rank order, self-disclosure and feedback, attraction and

bonding, listening and empathy, and support and caring. In contrast, avoidance and defensiveness, and conflict and rebellion dominated low cohesion groups.

Moreover, this review also found that populations were idiosyncratic in how they valued therapeutic factors. This point is illustrated by the results of a study on incest survivors by Bonney, Randall & Cleveland (1986), who found that the most striking differences in comparison with other psychotherapy groups was the high ranking of self-understanding and family reenactment. Llewelyn and Haslett (1986), further highlight the idiosyncrasy of populations in their examination of therapeutic factors in three different types of self-help groups. In their study three groups that typified the major areas of self-help (therapy groups, social support groups and health/disability groups) were chosen. The groups chosen to represent these areas were a group for people suffering from depression, a group for widowed people, and a group for people suffering from asthma. The sample consisted of 45 subjects, distributed as follows, 10 subjects in the group for depressives, 24 subjects in the group for widows, and 9 subjects in the group for asthma sufferers. Data were collected using an adaptation of Yalom's 12 factor questionnaire as per Butler and Fuhrman's 1980, study. The results indicated that members of groups concerned with social and personal support (widowhood), rated universality as the most helpful factor, whereas members from a group for the physically sick (asthma sufferers) rated guidance as the most helpful factor. By contrast, the group concerned with providing therapy for depressives reported cohesiveness to be the most helpful. Both Bonney, Randall & Cleveland, and Llewelyn and Haslett relied on self-report measures to come to their conclusions. The findings support Yalom's (1995), claim that the importance of therapeutic factors are likely to vary depending on the goals of the group.

In addition to identifying therapeutic factors that are specific to common theme groups, approaches to group therapy was another dimension identified in the research. Kapur and Miller (1987), compared Transactional Analyses groups (TA) with psychodynamic groups and found both similarities and differences existed across the two therapy approaches in the participants perception of most helpful factors. Subject's (34) were recruited from existing TA and psychodynamic groups to form the two groups for the study. A strength of this study was the even distribution of subjects and diagnosis across the two groups, with the TA group having sixteen subjects and the psychodynamic group having eighteen subjects. Both groups had an equal number of subjects with affective disorder, borderline personality and eating disorder. Yalom's 60 item questionnaire was used to collect the data. In their analysis of the data Kapur and Miller found that both groups rated self-understanding as the most helpful therapeutic factor, with the TA group ranking interpersonal learning (input and output) as the next most helpful therapeutic factors, whereas the psycho-dynamic group placed universality and cohesion in this category. While TA and psycho-dynamic groups both have therapeutic benefits their focuses are quite different. For example TA groups focus on developing the individual's ability to self nurture, whereas psycho-dynamic groups places emphasis on knitting the group together as a way of providing a therapeutic base for change (Kapur & Miller, 1987). Roak and Sharah (1989), add support to Kapur& Miller (1987), theoretical notion that psycho-dynamic groups tend to focus on developing cohesion by finding in their study on personal growth groups, psychotherapy groups and DUI groups (no explanation was given by the author as to what DUI stood for) that the that personal growth groups which are inclined to be more psycho-dynamic were more cohesive than the other two groups.

The relationship between therapeutic factors and outcome was also identified in this review as an area that had attracted some attention. Both Flower's (1987), and Kivlighan, Johnson and Fretz (1987), made attempts to determine the association between therapeutic factors and change. Flower's (1987), study on a therapy group examined the relationship between outcome improvement and curative factors. Improvement was measured through three separate interviews where the therapist filled out the same 80-item questionnaire developed by the author that covered every DSM-III diagnosis. The interviews were conducted prior to beginning the group and then twice at the end of treatment. The first of the two questionnaires filled out at end of treatment was done so from two perspectives, the first from the most pathological portrayal of the individual, and the second from the least pathological portrayal of the individual. This maximum-minimum procedure was a strength of the study because it helped to control for therapist bias in outcome ratings. Results showed a significant improvement between pre and post-treatment on the DMS-III diagnoses ( $F(1,42) = 10.47, p < .003$ ). Flowers found subjects who demonstrated a high outcome improvement also had a high agreement upon the rank ordering of therapeutic factors. Whereas subjects who did not score high on group satisfaction or demonstrate outcome improvement also differed considerably on the rank ordering of valued therapeutic factors. Similarly Kivlighan, Johnson and Fretz's (1987), study on a career counseling groups found that individuals who measured a high level of change on the My Vocational Situation Scale (MVS) rated different therapeutic factors as important than did those who showed a low level of change on the MVS.

## Conclusion

The majority of studies in this review focused on therapeutic factors in homogeneous groups. There was a smaller body of research that examined the relationship between

therapeutic factors and outcome (Flowers, 1987; Kivlighan et al., 1987; Kivlighan, 1991; Tschuschke & Dies, 1994). Furthermore, the preferred instruments used to collect data were Yalom's 60 item questionnaire or Q-sort, and the Critical Incident Questionnaire. For example out of the 23 studies reviewed 19 used either the Critical Incident Questionnaire or Yalom's 60 item questionnaire or Q-sort. One of the major limitations of the studies in the review was the heavy reliance on self-report questionnaires. There were however, some studies that used assessment scales to identify individual differences. Other limitations of studies were small sample sizes and uneven distribution of subjects across groups. It was also evident that there was a notable absence of observational methods used, in fact only one study out of the 23 studies review used observational methods (Tschusche and Dies, 1994). As a result there was an absence of observed behaviors associated with therapeutic factors.



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Table 1  
Comparison of Bloch and Crouch's (1985), and Yalom's (1970), classification of therapeutic factors

Bloch & Crouch's 1985 List	Yalom's 1970 List
1 Acceptance - the patient feels a sense of Belonging and being valued (cohesiveness)	Group Cohesiveness - the resultant of all the forces acting on all the members to remain in the group.
2 Universality - the patient discovers that he is not unique with his problems (universalization)	Universalization - disconfirmation of uniqueness in their problems
3 Altruism the patient learns with satisfaction that he can be helpful to others in group	Altruism - experience that they are important to Others in the group
4 Instillation of hope - the patient gains a sense of optimism about his potential to benefit from treatment	Instillation of Hope - a person gains sense of hope From treatment when they see how other people Cope with similar problems to themselves
5 Guidance - the patient receives useful information in the form of advice, suggestions, explanations, and instruction	Imparting information - to transfer information
6 Vicarious learning - the patient benefits by observing the therapeutic experience of fellow group members (spectator learning, identification)	Imitative Behavior - a person models themselves Upon aspects of other group members as well as the therapist.
7 Self-understanding - the patient learns something Important about himself, usually through feedback or interpretation (insight, intellectualization).	The Corrective recapitulation of the primary family Group - maladaptive behaviors from the past are Challenged in the group.

Table continues

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Bloch & Crouch's 1985 List	Yalom's 1970 List
8 Learning through interpersonal action - the patient learns from his attempts to relate constructively and adaptively within the group (interpersonal learning, interaction)	Interpersonal Learning - learning about oneself through interactions and reaction. Development of socializing techniques - by role playing different approaches to difficult situations or from feedback about their behavior in group.
9 Self-disclosure - the patient reveals highly personal information to the group and thus 'gets it off his chest'.	
10 Catharsis - the patient releases intense feelings which brings him a sense of relief (ventilation)	Catharsis - the release of feelings

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Table 2

## Studies on Inpatients

Author	Instruments	Type of group	Study focus	Findings
Kahn, Webster & Storck, 1986	Yaloms 60 item questionnaire & leader ratings	Awareness groups Focus Groups Psychiatric Patients Sample=25	Diagnosis and group focus as predictors of valued therapeutic factors	Diagnosis and group focus was not found to be a significant predictors of valued therapeutic factors.
Whalan & Muschet, 1986	Critical Incident questionnaire	Psychotherapy Psychiatric patients Sample=77	Consumers view of helpful aspects of group psychotherapy	Most valued therapeutic factors were found to be Altruism, universality, self- disclosure, guidance

Table continued



Author	Instruments	Type of group	Study focus	Findings
MacDevitt & Sanislow, 1987	Yaloms 60 item Questionnaire	Offender groups Sample=123	Examines if degrees of environment restriction effects perception of therapeutic factors valued	Catharsis was rated high by all groups. Cohesion was rated high only in the probation group.
Lovett & Lovett, 1991	Yalom's 60 item questionnaire	Therapy group Alcohol dependent Patients Sample = 70	Compares patient and therapists views on most valued therapeutic factors	Both therapists & patients perceived cohesion, self-understanding, and existential issues as most valued factors
Webster et al., 1992	Yalom's Q-sort questionnaire	Occupational therapy (OT), Psychotherapy, (PT), Psychiatric patients Sample=35	Comparing patients perception of curative factors in OT & PT groups	Both groups valued cohesion, interpersonal output, altruism and hope.

Table continued

Author	Instrument	Type of group	Study focus	Findings
Tschuschke et al., 1994	SCL-90, GAS, Target	Psychotherapy	Analysis of therapeutic	Cohesion was found to be
	Goal Attainment Scale	Neurotic and Personality	factors and outcome in	related to improvement
	Emotional Relatedness	disorder patients.	long term in-patient	outcome
	To Group, Kelly's Grid	Sample=15	groups	
	Video Obs. using SYMLOG technique			

Table 3

## Studies on Outpatients

Author	Instruments	Type of group	Study focus	Findings
Bonney, & Randal, 1986	Yalom's Q-sort	Psychotherapy Incest Survivors	Examines factors regarded as most and least therapeutic by group members	Self understanding, family re-enactment and cohesion were valued most . Least valued were guidance, altruism and hope
		Sample=7		
Llewyn & Haslett, 1986	Yalom's 60 item	Self-help groups	Exploration of factors perceived as helpful by members of self help groups	Widow groups valued Universality. Groups for asthma sufferers valued guidance. Group do depressives valued cohesion
		Widows, Asthma sufferers, and depressives Sample=45		

Table continued

Author	Instrument	Type of group	Study focus	Findings
Flowers, 1987	Yalom's Q-	Adults Sample=24	Perception of curative factors by patients who did and did not improve as a function of the group experience.	Author did not name factors. Subjects who did not improve did not agree with the other subjects who showed improvement
Kapur & Miller, 1987	Yalom's 60 item Questionnaire	Transactional Analysis Psychotherapy Adult Sample=34	Comparing TA and Psycho-dynamic therapy groups	Both groups viewed self-understanding as the most helpful therapeutic factor. TA groups ranked interpersonal learning (input and output) as next most helpful factors. Psycho-dynamic groups ranked universality and cohesiveness as next most helpful.

Table Continued

Author	Instrument	Type of group	Study focus	Findings
Kellermann, 1987	Questionnaire	Psychodrama Psycho-	Psycho drama participants	Most valued factors
	Constructed by author	drama participants Sample = 82	perception of therapeutic factors	emotional abreaction and cognitive insight.
Kivlighan, Johnsen & Fretz, 1987	MVS scale HCGW scale	Career Counseling Group Students Sample = 47	Participant's perception of change mechanisms in career counseling groups.	High change groups valued advise, hope, experimenting, and understanding feelings.
Kapur, Miller & Mitchell, 1988	Yaloms 60 item Questionnaire	Psychotherapy	Comparing therapeutic factors in Inpatient and Outpatient groups	Outpatients valued identification, altruism, and guidance. Inpatients valued guidance, identification and family re-enactment.

Table Continued

Author	Instruments	Type of group	Study focus	Findings
Kivlighan & Mullison, 1988	Critical Incident	Therapy Group	Examines stage of group and perception of therapeutic factors	Universality important in early group sessions.
	Questionnaire			Learning through interpersonal action
	The Check List of Interpersonal			important in the later stages of group.
	Transactions			
Roak & Sharah, 1989	Questionnaire	Personal growth	Examining the	All factors correlated
	constructed by author	Psychotherapy	relationship of group	significantly with
		DUI Group	cohesiveness to empathy, self- disclosure, acceptance, and trust.	cohesiveness. Personal growth groups had a higher level of cohesion than other groups.

Table continued

Author	Instrument	Type of group	Study focus	Findings
Hobbs , Birchell, Harte & Lacey, 1989	Critical Incident Questionnaire & therapist ratings factors in order of importance	Short term group therapy. Adult bulimic patients Sample = 5	Therapeutic factors most valued by bulimic patients.	Most valued factors were non-specific factors, learning from others experiences, realizing shared experiences, , and gaining hope from observing positive changes in others.
Braaten, 1990	SCL-90 Group Climate Questionnaire & Cohesion questionnaire constructed by author	Growth Groups Students and business leaders Sample = 211	Critical incidents in high & low cohesion groups	High cohesion groups high in self-disclosure & feedback, attraction & bonding, empathy. Low cohesion groups high in avoidance & defensiveness, conflict & rebellion.

Table continued

Author	Instrument	Type of group	Study focus	Findings
Nehls, 1991	Yaloms 60 item	Group therapy	Examines the process &	Universality & existential
	Questionnaire	Borderline personality	outcome of group	factors were rated as
	Brief Symptom	disorder patients	therapy for this	helpful by this sample.
	Inventory	Sample = 8	population	Contrary to other studies
	Goal Attainment Scale			with same population.
Kivlighan & Goldfine, 1991	Critical Incident	Personal growth group	Therapeutic factors as a	Universality and hope
	Questionnaire &	University students	function of stage of	high in early groups.
	Interpersonal Check list	Sample = 36	group development and	Catharsis increased
	Group climate scale		participant	across groups. Affiliated
			interpersonal attitude.	participants valued
				cognitive factors.
				Nonaffiliated participants
				valued behavioral factors.

Table continued



Author	Instrument	Type of group	Study focus	Findings
Colijn, Hoencamp, Nijders, Van Der Spek, & Duivenoorden, 1991	Yaloms 60 item Questionnaire	Long term therapy groups Mental health patients Sample = 134	Testing and refining a Dutch version of Yalom's questionnaire for curative factors.	Results consistent with American samples. Valued factors were catharsis, self- understanding, interpersonal learning.
McLeod & Ryan, 1993	Yaloms Q-sort &	Therapy group Older women Sample = 8	Investigation of therapeutic factors experienced by members of a group for older women	Existential awareness most valued. These finding are in contrast to other studies on out- patient groups who valued interpersonal awareness

Table continued

Author	Instrument	Type of group	Study focus	Findings
Mahon & Kempler, 1995	Yalom's Q-sort  CAST-Screening Test	Psychotherapy  Adult children of alcoholics.  Sample = 84	Perceived effectiveness of Therapeutic factors for ACOA's & Non- ACOA's	Self-understanding, cohesion, catharsis, and interpersonal learning valued by both groups
Shaughnessy & Kivkighan, 1995	Critical Incident questionnaire  Trainer Behaviour Scale	Personal growth group  University students  Sample = 114	Classification of group participants by their perception of therapeutic factors most helpful	Four types of participants identified, broad spectrum responders, self-reflective responders, other-directed responders, and affective responders

Running head: Group behavior

Group member and group leader behavior: Do they make a difference to feelings of cohesion and universality?

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### Abstract

This study examined the association between observational measures of group behavior and self-report measures of two therapeutic factors (cohesion and universality). Thirty groups were observed which were part of a treatment program for family and friends of people with alcohol and drug use problems. Group member behaviors that were observed were the number of specific statements of personal sharing and the number of times they related to others. Group leader behaviors that were observed were reflecting and linking skills. The following hypotheses were supported, the more personal sharing individuals engaged in the higher they perceived cohesion; the higher the average level of sharing in the group the higher group members perceived cohesion; the higher the average level of relating by group members the higher they perceived universality; the more reflecting group leaders did the higher the average level of sharing in the group.

Group member and group leader behaviors: do they make a difference to feelings of cohesion and universality?

Group work has become a major treatment method used in a variety of settings and populations (Andrews, 1995; Corey & Corey, 1992; Forsyth, 1999; Yalom, 1995). One of the first practitioners to recognize the power of groups was Joseph Pratt in the early 1900's. His work with tuberculosis patients, was in essence a common theme group. A common theme group is one which specific problems are common to the entire group membership (Andrews, 1995). In the years following Pratt's early work, there were several attempts to identify the components of groups that are responsible for positive changes in participants (Corsini & Rosenberg, 1955). One of the pioneers in identifying the therapeutic components that promote change in groups was Irvin Yalom. Based on a synthesis of earlier research (Corsini & Rosenberg, 1955) along with his own research and clinical experience, Yalom (1970) identified 12 therapeutic factors (at that time Yalom used the term "curative factors") that he believed were responsible for the therapeutic effect of group psychotherapy. He labeled these 12 therapeutic factors as follows; self-understanding, interpersonal learning (input and output), universality, instillation of hope, altruism, recapitulation of the primary family group, catharsis, cohesiveness, identification, guidance, and the existential factor (Yalom, 1970, p.5). In his discussion of therapeutic factors in the context of the change process Yalom, argued that people in the same group might be benefited by widely differing clusters of therapeutic factors. He went on to say that therapeutic factors are also interdependent and neither occur nor function separately. In addition, they might

also represent different parts of the change process, as some refer to actual mechanisms of change, while others might be more accurately described as conditions of change.

Since Yalom's (1970), first classification of factors there has been a groundswell of research in the area. Bloch and Crouch (1985) conducted an extensive review of the literature on therapeutic factors. They found that the various classification efforts over more than twenty-five years have considerable agreement about the basic factors in group therapy. Further, terminology also tended to remain consistent over the years with general patterns evolving. For instance it was found by Bloch and Crouch (1985), that the number of factors identified and largely agreed upon ranged between nine and twelve, and covered three spheres; emotional, cognitive, and actional (behavioral). Furthermore, in its entirety, the concept of a therapeutic factor appears to rest on the premise that the process of group therapy embodies a finite number of elements distinguishable from one another by virtue of their highly specific effects on the group member.

It has also become evident that whilst all of the factors identified are considered helpful, there are some factors that tend to be more valued by group members than others (Butler & Fuhrman, 1983; Kivingham & Mullison, 1988; Yalom, 1995). For example, group cohesiveness according to Yalom is not only a potent therapeutic force in its own right, but perhaps more importantly it is a necessary precondition for other therapeutic factors to function optimally. Braaten (1989), found in a Rogerian training group that group members reported greater benefits when a high level of cohesion existed in the group. Tschuschke and Dies' (1994), add supports to the importance of cohesion in the change process in their study on two long-term inpatient groups for severely disturbed neurotic and personality disordered patients, in that cohesion was significantly correlated with improvement ( $r(7) = .74, p < .05$ ;  $r(7) = .94, p < .01$ ). Improvement was based on a composite outcome score from four measures (Symptom Check List, the Global

Assessment Scale, the Target Goals-Patients Scale, the Goal Attainment Scale). In addition Tschuschke and Dies identified that when cohesion formed early in the group there was a tendency for clinical improvement. Cohesion was measured in the early session of the group and again in later sessions using the Stuttgarter Bogen Emotional Relatedness to Group Scale. The first group ran for a total of 83 session and the second group ran for a total of 93 sessions (once per week). The authors did not indicate at what weeks cohesion was measured. A major strength in Tschuschke and Dies study was their use of several instruments in their attempt to determine the association between therapeutic factors and outcome. Another strength of their study was that it was longitudinal with outcome assessments carried out at 12 months and 18 months following treatment. Furthermore, their study was one of the few studies to use observational methods. However, the one limitation of this study was the small sample size of 15 subjects.

Despite its heralded importance, cohesion is a concept that has not been easily defined (Evans & Jarvis, 1980; Hogg, 1993). Yalom (1995) refers to cohesion as the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by other members. Similarly Andrews (1995), describes cohesion as the individual's feelings of belonging, reciprocal friendliness, and interpersonal valuing that lead to feelings of acceptance. Being understood, accepted and supported are very important, and crucial in cases where a group member has revealed something which might be perceived as unacceptable or shameful (Andrews, 1995). It appears from this literature that cohesion is the bonding element in groups (Andrews, 1995; Yalom, 1995). As suggested by Forsyth (1999), without cohesion, feedback would not be accepted, norms would never be developed, and groups could not retain their members. Cohesion is not something that is present immediately a group comes together, it is

developed over-time when trust and support are felt (Kivingham & Mullison, 1988; Tschuschke & Dies, 1994; Yalom, 1985). Furthermore, the development of cohesion in groups can be influenced by whether the group is open or closed. Open groups according to Brabender (1988), have been found to struggle in establishing and maintaining group cohesiveness because of the constant change in group membership (Brabender, 1988). Andrews (1995), suggests that if people are informed how the group works and normalising their problems by telling them other people in the group have similar issues to them prior to commencing the group it helps to foreshadow the development of group cohesion and universality.

Like cohesion, universality is another therapeutic factor that has been identified as being an important element in engendering trust and hope, especially in the early stages of group development (Kivlighan & Goldfine, 1991). As with other therapeutic factors universality is not easily defined, it merges with other factors. Forsyth (1999), refers to universality as the recognition of shared problems, and the reduced sense of uniqueness. As participants perceive their similarity to others and share their deepest concerns, they benefit further from the accompanying catharsis and from ultimate acceptance by other members. There appears to be a reciprocal interaction between acceptance, universality, and self-disclosure (Andrews, 1995). This synergistic interaction is likely to produce the effects associated with increased cohesiveness. As inter-group acceptance and feelings of similarity increase, the level of self-disclosure will likely increase (Forsyth, 1999).

Whilst it has been argued that cohesion is important for groups to function, the behavioural elements that encourage feelings of acceptance and group cohesiveness have not been researched to the same extent (Forsyth, 1999). In fact the majority of research to date has been self-reporting questionnaires with a deficit in behavioral observations (Forsyth, 1999;



McKenna,1999). The literature identifies that one behavioral factor that is associated with cohesion is self- disclosure. Self-disclosure has been found to be a reciprocal interaction with cohesion in that self disclosure produces the effects associated with increased cohesiveness and the level of self-disclosure is likely to increase the more cohesive the group is (Andrews,1995; Bendar, Weet, Evensen, Lanier & Melick, 1974; Braaten, 1990; Corey & Corey, 1992; Forsyth,1999; Stokes, Fuehrer, & Childs, 1983). Braaten's (1990), study on 26 therapy groups found that when there was a high level of cohesion in the groups there was also a high level of self-disclosure. In general terms self-disclosure refers to a group members direct communication of personal material about themselves to the group (Bloch & Crouch, 1985). Stokes (1983), found that groups in which members disclosed about intimate topics were perceived as more cohesive than groups in which members disclosed about less intimate topics. Based on this information, it highlights the importance for further research to be carried out using observational methods that measure behavioural factors in groups.

While therapeutic factors are critical in the process of change it would be remiss not to consider group leader behaviours in this process. Group leader behaviors that have been found to encourage self-disclosure and feelings of cohesiveness are the listening skills, such as body language, and reflective and supportive responses (Andrews, 1995; Anderson & Robertson, 1985; Bolton, 1987). Reflective responses provide a mirror to the speaker. In a reflective response, the listener restates the feeling and/or content of what the speaker has communicated in a way that demonstrates understanding and acceptance (Bolten, 1987). In a like manner, linking similarities between group members helps them see common concerns and facilitates identification between members which has been found to foster universality in groups (Andrews,1995; Anderson & Robertson, 1985). By verbally naming common experiences,

feelings, or thoughts between group members, it helps people to become aware of their mutual situations (Andrews, 1995).

In a recent review of the research into therapeutic factors McKenna (1999), noted that studies mostly focused on examining what therapeutic factors are most valued in groups for particular populations. It was further noted that the methods used to measure therapeutic factors were mainly self-reporting questionnaires (Forsyth, 1999; McKenna, 1999). In addition there was also a noted absence in the research of observational methods used to measure the association of group member behaviours and therapeutic factors (H. Andrews, personal communication, March 24, 1999; Forsyth, 1999; McKenna, 1999).

The present study examined the association between group interactions and perceived therapeutic factors (cohesion and universality) using both observational and self-report methods. Group member behaviors observed were personal sharing and relating to others. Group leader behaviors observed were linking and reflecting. This study examines the association between group interactions and perceived therapeutic factors from two perspectives. The first part of the study, group member behaviors and therapeutic factors across individual were tested. The two hypothesis tested were: (1) The more personal sharing a person engages in, the higher they will rate perceived cohesion; (2) The more times a person relates to others in the group, the higher they will rate perceived universality. The second part of the study tests group member behaviors, group leader behaviors and therapeutic factors across groups. Six hypothesis were tested: (3) The higher the averaged sharing of group members in the group, the higher the average rating of participants' perceived cohesion; (4) The higher the averaged relating to others in the group, the higher the average rating of participants' perceived universality; (5) The more a group leader demonstrates reflecting skills the higher the average rating of participants' perceived

cohesion; (6) The more linking a group leader does the higher the average rating of participants' perceived universality; (7) The more a group leader demonstrates reflecting skills the more participants will engage in personal sharing; (8) The more linking a group leader does the more participants will relate to others. A third series of data were also collected to evaluate further associations between group interactions and therapeutic factors that may be used to form hypothesis for the future.

## Method

### Design

The associations between group interactions, group leader behaviors and participants' perceptions of universality and cohesion were examined using a correlation design

### Participants

There were a total of 61 subjects who participated in this study. Participants were 14 male and 47 female adults attending group therapy as part of treatment programs for family and friends of people with alcohol or other drugs use problems. The sample consisted of 18 partners, 2 family members, 21 parents, and 20 adult children of problem drinkers or drug users. Participants' age ranged from 20 to 71 years ( $M = 43$ ,  $Mdn = 43$ ). Thirty subjects out of the 61 subjects were also the sample for across individual measures. This sample consisted of 6 males and 24 females, with an age range from 24-71 ( $M = 42$ ,  $Mdn = 46$ ). The treatment programs were conducted at a non-government Alcohol and Drug Agency. Prior to enrolling in the treatment program participants attended an initial assessment interview where they were explained the process and content of the program. The programs involved a once a week session consisting of ten minutes

of relaxation, a twenty-minute psycho-education session followed by group therapy for approximately one hour and thirty minutes. The groups were open-ended.

Group facilitators had varying qualifications and experience. Two facilitators were currently working towards their Masters degree (psychology), with approximately four years experience in group facilitation. One was a psychologist who has had seven years experience running groups in this setting. Two were students who had undergone in-house training and had approximately 18 months experience. One was an ex-client who had been trained in-house and had seven years experience facilitating groups in this setting. Another facilitator was also an ex-client who had been facilitating groups for six months after completing in-house training and a three month probationary period. The remaining four facilitators were trainees who had recently completed the in-house training and were mainly observing the groups with minimal participation.

### Procedure

Prior to data collection written permission to record group interactions and collect demographics from participants files was obtained from each subject. A letter was given to each subject outlining confidentiality, the aim of the study and the requirements of the participants. If participants did not want to be involved in the research they had the option of being assigned to another group not involved in the study.

Separate sets of data were collected across individuals and across groups. The data collected, to test the first two hypotheses (correlation across individuals), were obtained from the thirty participants who attended the first session of each group observed. To test the other six hypotheses (correlation across group) data from six separate groups were collected over five

sessions, making a total of thirty group sessions observed. The number of participants in each group ranged from 3 to 9 with all but two groups having 4 or more participants.

### Observational Measures

A recording chart was used to identify the measures of "personal sharing" and "relating to others" by group members and "reflecting" and "linking" by group leaders.

Sharing. Personal sharing was defined as sharing personal information about one's situations, feelings or thoughts (opinions, attitudes, and beliefs). Counting distinct events was chosen to quantify personal sharing. For example the following verbal communication would equal four counts; "I can see I suppress my anger. I tend to take my feelings out on other people. Then they get angry with me and I end up doing things for them I don't really want to". An individual participants score was simply the total count of personal sharing during that group session. For across group analysis, the data for the amount of sharing were averaged.

Relating. Relating to others was defined as any explicit verbal expression of having a similar experience to that expressed by another group member. For example if a group member stated; "I had something like that happen to me the other day" or "that's sort of how I feel". If a group member related to more than one aspect of another member's experience, it was recorded as two (or more) instances of relating to others. An individual participants score was simply the total count of relating to others during that group session. For across group analysis, data for the amount of relating to others were averaged.

Linking. Linking by group leaders was defined as linking similarities between members, linking what one member has disclosed to the group (e.g. "has anyone else ever had the same thing happen to them") and linking to common themes in the group. These interactions were counted for each group session.

Reflecting. Reflecting was defined as reflecting feelings, meaning (tying feelings to content), thinking, and paraphrasing. These interactions were counted for each group session.

### Self-Report Measures

A questionnaire was administered at the end of each group session to obtain data on group members' perceptions of cohesion and universality. The questionnaire required group members to complete four 10-point rating scale (see Appendix). The first scale and fourth scales were measuring variables that will be used in exploratory analyses and are not related to the hypotheses. The first scale measured if participants felt better by asking the question "do you feel better for having talked about your situation". The fourth measured scale measured helpfulness by asking the question " did you feel the group was generally helpful for you".

The second scale measured cohesion defined as "the condition of members feeling warmth and comfort in the group, feeling they belong, and unconditionally accepted and supported in the group" (Yalom, 1995). The third scale measured universality defined as "the recognition of shared problems, and the reduced sense of uniqueness" (Forsyth, 1999).

### Pilot Study

A pilot study was conducted on an in-house training group over three sessions to test inter rater reliability of all the observational measures. The two researchers were both Psychology Honors students. One was the author of this paper. A Pearson Correlation was applied to determine consistency between rater's coding of interactions. A inter-observer reliability of or above .9,  $p < .01$ . was achieved across all five variables by the end of the third training session.

## Results

All statistical analyses was conducted using SPSS statistical package 8.0.

A number of observed measures had one or two outliers. Outliers were identified from the diagnostics, Boxplot and Normal Probability Plots and Detrended Normal Plots. For group data, outliers from group member behavior tended to occur in groups with small numbers. For example the two groups with the highest averages of personal sharing only had three participants and the average number of personal sharing statements for these groups were 159 and 131. Across all the other 28 groups the average sharing ranged from 107 to 38. For that reason the data were analyzed using Spearman's Rank Order Correlation. By using ranked data instead of raw data the effect of outliers is eliminated.

Data are reported in three sections. The first section reports the examination of the two hypotheses pertaining to individuals. The second section reports the examination of six hypotheses that examine the associations occurring between the observational measures and perceived therapeutic factors (cohesion and universality) across group sessions. The third section reports a number of exploratory analyses.

#### Across Individuals

As hypothesized, the more personal sharing individuals engaged in the higher they perceived cohesion  $r(30) = .468, p < .01$ . Scores for cohesion ranged from 3 to 10 ( $M = 8.43$ ,  $SD = 1.75$ ). The hypothesized association between the amount of relating to other by an individual and universality not found  $r(30) = .158, p > .05$ . Despite no positive relationship being found between relating to others and universality, 66% or 20 out of 30 individuals scored seven or above on the rating scale for the question pertaining to universality ( $M = 7.5$ ,  $SD = 2.02$ ).

#### Across Groups

As hypothesized the higher the average level of sharing by group members, the higher the average rating of cohesion  $r(30) = .470, p < .01$ . The hypothesized association between the level

of relating to others and universality was supported,  $r(30) = .470, p < .01$ . The hypothesized association between the amount of reflecting a group leader does and cohesion was not found  $r(30) = .062, p > .05$ . Despite no association being found between group leader reflecting and group cohesion, across all groups, cohesion was rated seven or above on the rating scale. There was no association found between the amount of linking a group leader does and perceived universality  $r(30) = -.173, p > .05$ . Across groups 86% or 24/30 groups rated universality above seven on the rating scale. The amount of linking group leaders did, ranged from 5 to 66, with only 23% of group leaders linking 20 or more times across a group session. As hypothesized, the more reflecting a group leader did the higher the average amount of sharing by group members  $r(30) = .426, p < .01$ . The hypothesized association between the amount of linking a group leader does and people relating to others was not found  $r(30) = .002, p > .05$ .

#### Exploratory Data

In the across individuals analyses of the exploratory question "do you feel better for sharing" was found to be significantly correlated with the amount of sharing individuals engaged in  $r(29) = .487, p < .01$ , and the amount of relating to others they engaged in  $r(29) = .369, p < .05$ . The question "do you feel the group was generally helpful to you" was significantly correlated with the amount of sharing individuals engaged in,  $r(30) = .317, p < .05$ , and the amount of relating to other,  $r(30) = .381, p < .05$ . (see Table 1)

For across groups the analyses of the exploratory question "feeling better for sharing" was significantly correlated with the higher the average level of sharing by group member  $r(29) = .439, p < .01$ . No association was found between the exploratory question "do you feel the group was generally helpful to you" and the average level of sharing in the group  $r(30) = .233, p > .05$ . A significant correlation was found between the average level of relating in the group and



questions "feeling better for talking"  $r(29) = .550$ ,  $p < .01$ , and for "feeling the group was generally helpful",  $r(30) = .397$ ,  $p < .05$ . No associations were found between group leader behaviors and the two exploratory questions (see Table 2).

### Discussion

The findings from the present study support four out of the eight hypotheses. For across individuals the hypothesis that, (1) the more an individual shared in the group the higher they would rate cohesion, was supported. These findings add support to Forsyth's (1999), claims that cohesion has a reciprocal relationship with self-disclosure, in that the more people share the more they feel accepted and the more they feel accepted the more they share.

The hypothesis for across individuals, (2) that the more people relate to others the higher they will rate universality was not supported. Universality is formed when people feel that they are not alone in their problems and has a reciprocal interaction with acceptance and self-disclosure (Andrews, 1995; Forsyth, 1999; Yalom, 1995). Despite no significant relationship found between relating to others and universality, individuals scored high on the universality measure with 66% of individuals rating seven or above on the scale ( $M = 7.5$ ). Therefore, although the hypothesis was not supported a high percentage of people in the group still indicated that they had a sense of universality. This suggests that universality was present but did not manifest in verbal communication. Adding support to this suggestion is the association between relating to others and universality across groups being supported (Hypothesis 4). A further explanation for these differences might be that universality is developed in groups through people listening to other people in the group relating. Therefore, universality maybe more of a felt experience that does not necessarily manifest into verbal communication. Furthermore, anecdotal observations made by the two raters indicated that there was a lot of non-

explicit relating such as nodding, conversations continuing in the same vein and the triggering of emotions when others in the group shared occurred in the groups. Therefore, because only explicit statements of relating to others were recorded, relating to others may have been underestimated. Thus, the non-significant association found across individuals could have been due to the inadequacy of the measure used for recording "relating to others"

A further explanation for the high rating of universality by group members could have been that the psycho-educational presentation participants attend prior to group fosters universality. The psycho-educational presentations cover a variety of topics that are related to issues associated with being effected by another person's alcohol or drug misuse problems. Identifying with the information presented could give people a sense of universality. Andrews (1995), argues that when people are given information that others have similar problems to them prior to the commencement of group therapy it can help to foreshadow the development of group universality. Therefore, the development of universality may have been foreshadowed through the process of the psycho-educational session.

Three out of the six hypotheses for across groups were supported one of which has already been discussed above (Hypothesis 4). Hypothesis (3) the higher the average sharing by group members the higher group members will rate cohesion, was supported. These findings add support to Braaten (1990), who found that groups with high levels of cohesion also had high levels of self-disclosure. In addition to the reciprocal interaction between self-disclosure and cohesion, high levels of cohesion in groups was found by Tschuschke and Dies (1994), to be related to outcome improvement. These finding therefore could have important implications for clinicians and treatment programs as well as for training group leaders. Furthermore, these findings also challenge Brabender's (1989), claim that it is difficult to establish and maintain

cohesion in open-ended groups. The groups in the study most weeks had either new participant's joining or existing participants leaving the group because they had completed the 12 sessions of the treatment program.

The remaining four hypotheses measured group leader behaviors. Hypothesis (5) the more a group leader demonstrates reflecting skills the higher the average rating of participants' perceived cohesion was not supported. Despite no association between group leader reflecting and cohesion, across all groups the average scored on cohesion was high ( $M = 8.5$ ). While group leader reflecting was not found to be associated with cohesion, there was an inter-dependent relationship between group leader reflecting, and cohesion. The inter-dependent relationship being that the amount group members shared was associated with cohesion and the amount of reflecting a group leader demonstrated was related to the amount of sharing in the group. This is confirmed by Hypotheses (7) being supported (the more a group leader demonstrated reflecting skills the higher the average level of sharing will be in the group). In addition anecdotal observation made by the two raters revealed that the more reflecting group leaders did the better the quality of sharing by group members. For example when group leaders demonstrated a lot of reflecting group members shared at much deeper level which often lead to cathartic experiences.

There were no relationships found between group leader linking and universality across groups (Hypothesis 6) or group leader linking and relating to others across groups (Hypothesis 8). Therefore, the results do not support the claims in the literature that linking facilitates identification between member's, which in turn fosters universality in groups (Anderson & Robertson, 1985). An explanation for this could be that the simple measure of counting employed to record linking by group leaders may not have captured what the literature is defining as linking. For example counting does not separate poor or mediocre linking from really

good linking. It might be that the level of linking the theory refers to when it associates it with fostering universality might be at a higher level than what was recorded in this study. Therefore the quality of group leader behaviors not the quantity might be a better measure. To obtain data of this nature observations would need to be done via video recordings. This was a consideration for this study however it was not acceptable by the agency where the research was being conducted.

Therefore perhaps a limitation of this study was the inadequacy of measures used to observe group leader behavior. Another variable that was not accounted for in this study was pre-existing cohesion and universality that may have been present due to the groups being already in progress at the commencement of data collection. The groups being open-ended meant some of the participants had been in the group for several sessions when others were just starting. Therefore caution needs to be applied when considering the findings of this study.

It is recommended for future research that a more comprehensive measure be used to observe group leader behavior that can incorporate the quality and not just the quantity of group leader behaviors. Nevertheless, the strengths of the study are that the population was representative of a broad spectrum of the community. Therefore in comparison with Tschuschke and Dies' (1994), study who also used observational methods, the current study has a greater application in the wider community. Furthermore, the employment of self-reporting and observations measures allowed this study to examine therapeutic factors from two perspectives. The study also had good inter rater reliability across all observed variables. In sum the findings from this study have attempted to provide some behavioral evidence for therapeutic factors.

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Authors note

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Table 1

Exploratory questions across individuals

	Felt better for talking	Felt the group was helpful
Amount of sharing	.487** N = 30	.317* N = 30
Amount of relating to others	.369* N = 29	.381* N = 30

\*\* Correlation is significant at the .01 level (1-tailed).

\* Correlation is significant at the .05 level (1-tailed).

Table 2

Exploratory questions across groups

	Feel better for talking	Felt the group was helpful
Average level of sharing in the group.	.439** N = 29	.233
Average level of relating in the group	.550** N = 29	.397* N = 30
Amount of reflecting by group leader	.236 N = 29	.121 N = 30
Amount of linking by the group leader	-.128 N = 29	-.067 N = 30

\*\* Correlation is significant at the .01 level (1-tailed).

\* Correlation is significant at the .05 level (1-tailed).

## Appendix

## Appendix

***Please read each question carefully and indicate how you feel about today's group session by circling a number on the scale provided.***

**1. Do you feel better for having talked about your situation?**

[illegible]

## 2. Do you feel accepted by the group?

[illegible]

**3. Did you feel that in today's group that other people have similar problems to me?**

[illegible]

**4. Did you feel the group was generally helpful for you?**

[illegible]

***Thank you***

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Appendix A

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Appendix B

## **INFORMATION SHEET**

**Title of project:** Group Interactions and Group Members Perceptions of Group

### **IMPORTANT**

**It is very important that you read and understand all the details in this sheet BEFORE giving consent. Please ask ANY questions you have.**

I am Nicki McKenna, and this study is part of my Honours in Psychology at Edith Cowan University. The intention of this study is to investigate if certain group interactions are related to how clients feel about the session. To obtain data for this study it will be necessary for either myself or my research assistant to sit in the group and observe group interactions. It is estimated that we will sit in your group for approximately six separate sessions. You will be asked to:

1. Give permission for myself or my research assistant (Kate Negoiscui) to sit in group and record interaction between group members and facilitators.
2. Give permission for the researcher to obtain your age and gender from your client file.
3. Fill in a written questionnaire at the end of each group session.

**It should take about two minutes for completion of the questionnaire.**

***The most important issue is your consent to participate. Please note carefully that:***

- The School of Psychology, Ethics Committee, at Edith Cowan University has approved this project.
- You will be required to write your name on a tear off slip of paper attached to the questionnaire. This is so we can match the questionnaire response to that particular individuals interactions in group. Your name will be removed and shredded and each individual will be given a code number. The only person who will know your identity is the researcher who was observing your group. All researchers are Holyoake staff.
- At no time will details of what you say in group be recorded. Observations will be made only on interaction that occur.
- Your participation is entirely voluntary. If you decide not to participate in the study you will be assigned to a group that is not involved in the study.
- Findings from the research will be submitted for publication. No details will be disclosed that might identify any persons involved in the study.
- I Nicki McKenna can be contacted at the Holyoake Institute on 9328 9733 or my supervisor Greg Dear can be contacted at Edith Cowan University on 9400 5052 if you have questions regarding this research.

***Please keep this document for your information.***

**Declaration:**

I have read all the information given on the attached sheet and any questions I have asked have been answered to my complete satisfaction. I agreed to participate, realizing that I may withdraw at any time and be allocated to a group not involved in the research. I agree that research data for the study may be published provided my name or any other identifying information is not used.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

# Appendix Recording Instrument

Participants	Sharing	Relating	Reflecting	Linking
Facilitator 1				
Facilitator 2				
1				
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3				
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